

1. PPACA Key Provisions

The PPACA, “Patient Protection and Affordable Care Act”, represents far-reaching changes in the health sector, including mandating coverage for most people, “pay or play” requirements on many large employers, expanded eligibility for Medicaid, federal premium subsidies for many individuals and families, and a new system of health insurance exchanges for facilitating coverage. Additional provisions would reduce Medicare cost updates and increase Medicaid support for community based care. PPACA also includes provisions to increase federal tax revenues through a surcharge on high-income taxpayers, an excise tax on high cost health plans, and other taxes and fees.

2. Impact on Overall Alaska Health Care Expenditures and Enrollment

We have estimated the effects of the PPACA on overall Alaska health care expenditures and health insurance coverage. In addition we have developed an initial high level estimate of how the PPACA would impact Alaska health care providers, households, businesses, and the overall Alaska economy. The costs, savings and changes in health insurance coverage presented here represent MAFA’s best estimates based on CBO, CMS, RAND and other health reform analysis and multiple data sources and reasonable first order assumptions regarding individual, employer and health plan responses to federal legislation, together with our analysis of the likely changes in the cost and use of health care services. Although we believe that these estimates are reasonable and fairly portray a range of likely future effects of the PPACA, these estimates are subject to a high level of uncertainty due to the comprehensive nature of the federal reform that is slated to occur over the course of a decade.

Our preliminary estimates for impact of the PPACA on overall Alaska health care expenditures and enrollment include:

2.1. Enrollment

2.1.1. By 2019, when the comprehensive reforms of the PPACA are in full effect, we expect an additional 60 thousand U.S. citizens and other legal residents would have health insurance coverage meeting the qualifying coverage requirements; reducing the proportion of the Alaska population without insurance by roughly half.

2.2. Expenditures

2.2.1. By 2019, we project the total incremental cost of *health insurance expansion and new insurance requirements* to approach ~\$560 million (+4% of total health expenditures) in Alaska in 2019 in nominal dollars.

2.2.2. The increase in costs associated with insurance coverage expansions and new insurance requirements will be offset by ~\$140 million (-1% of total health care expenditures) in cost containment consisting of: a) reductions in Medicare reimbursement updates, b) reductions in reimbursements from Medicaid and other public and private insurance providers c) reductions in utilization trends associated with reductions in coverage trends as “high cost” health plans are subject to the new 40% excise tax and employers and employees shift compensation away from health benefits in favor of wages.

3. Impact on Alaska Providers

Our preliminary estimates for impact of the PPACA on Alaska health care providers include:

- 3.1. Overall, we expect health care providers to see an increase of roughly +3% (~\$400 million) in total health care expenditures driven in large part by increased demand for services from the newly insured.
- 3.2. While total revenues are expected to increase, it is not clear whether the incremental revenues to serve the newly insured population will exceed the incremental costs and whether the resulting margins of providers will increase, stay the same or decrease.
 - 3.2.1. Public and private stakeholders who buy insurance and medical care are generally expected to become increasingly focused on value in their purchases and health care providers will be expected to become more efficient and effective. We note that prominent national estimates suggest that in aggregate hospitals will see lower margins and physicians will see higher margins as a result of the comprehensive reform¹ and that some hospitals may see margin reductions and become unprofitable.²
 - 3.2.2. We also note that, in aggregate, Alaska hospitals and physicians appear to have both higher financial margins and more capacity (FTE per occupied bed, patient encounters per year per FTE) than aggregate averages in other states³ and as a result may have more collective potential capacity to reorganize how health care is delivered and remain profitable while still meeting the challenges of providing local community access to modern care.
 - 3.2.3. The relatively small, dispersed, transient and fragmented Alaska market of employers, payers and providers may present particular challenges for those seeking to improve the many and varied payment and delivery systems.

4. Impact on Alaska Households

- 4.1. Overall, we expect Alaska households to see no significant change in their *aggregate* spending associated with the PPACA. This reflects the net effect of new federal support for the Medicaid Expansion and federally subsidized insurance available through the Exchanges less new taxes and fees and new premium and out of pocket costs for newly mandated insurance that is not covered by subsidies.
 - 4.1.1. The estimated change in aggregate household spending on health insurance and health care services is sensitive to assumptions about how many employers drop or add health

¹ See for example, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers", Staff Working Paper #11, June 8, 2010; pages 49-52; hospital net incomes expected to *decrease 1.7%* while physician net incomes are expected to *increase 1.6% to 6.4%* depending on adjustments in the Sustainable Growth Rate (SGR) formula.

² See for example, CMS Office of Chief Actuary, PPACA Memo, April 22, 2010, page 10, "Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers [hospitals] would become unprofitable within the 10-year projection period as a result of the productivity adjustments [reductions in Medicare updates to help control Medicare cost growth]."

³ Ingenix Almanac of Hospital Financial and Operating Indicators, 2011

coverage, whether all of the resulting savings/costs associated with changes in pre-tax health benefits are shifted to the employee in the form of taxable wages,⁴ the relationship between future marginal tax rates and high cost health plan excise taxes, and how many individuals chose to buy insurance vs. pay a penalty.

4.1.2. While the *aggregate average change* in household spending may be roughly zero, the PPACA provisions drive a number of changes in the *distribution of spending* that are noteworthy.

4.2. Uninsured

4.2.1. We expect a net decrease in the number of uninsured in Alaska on the order of 60 thousand – representing the net effect of several shifts in coverage. First, an estimated 34 thousand would gain primary coverage as a result of the expansion of Medicaid eligibility to all legal resident adults under 138 percent of the Federal Poverty Level (FPL). In addition, roughly 6 thousand people with employer-sponsored coverage would enroll in Medicaid for supplemental coverage. Another 56 thousand persons, some of whom currently purchase individual and family coverage in the nongroup market, some of whom currently obtain coverage from their employer, and many of whom are currently uninsured, would receive individual coverage through the newly created Exchange, with roughly 80% of those qualifying for federal premium and cost-sharing subsidies which in aggregate cover roughly 60% of the total cost of health insurance premiums and out of pocket costs, leaving the newly insured to cover 40% of the cost of health care up to an “affordability limit” that ranges from 2.0% to 9.2% of income across the range of 138% of FPL to 400% of FPL.⁵

4.2.2. The net effect of these provisions is to transfer health insurance and health care costs from an older mid to low income demographic in fair to poor health toward a younger mid to high income demographic in excellent/very good health.

4.3. Insured/Covered

4.3.1. Large Group Market (>50 employees)

4.3.1.1. We expect a small net *decrease* (1-2%) in the cost of employer sponsored health insurance (ESI) as costs associated with the uninsured previously borne by ESI margins are shifted to the new federally supported health insurance programs.

4.3.2. Individual/NonGroup Market

4.3.2.1. We expect an increase (+20%) in the cost of insurance for individuals with incomes above 400% of FPL (\$56,000 individual, 2011 dollars) primarily associated with increases in insurance coverage required and a slightly wider range of benefits required to meet new statutory minimums.

4.3.2.2. For individuals with incomes below 400% of FPL, subsidies, penalties and exemptions vary according to income.⁶

⁴ In general, we assume that changes in employer health benefit costs are passed back to workers in the form of wage adjustments consistent with economic research on the relationship between wages and benefits over time.

⁵ See for illustrative examples “Premiums and Subsidies”, pages 191-234 of *Selected CBO Publications Related to Health Care Legislation*, 2009-2010, December 2010.

⁶ Ibid.

- 4.3.2.3. Due to the tightening of age bands, i.e., the difference in prices between young and old demographics which tended to follow actuarial cost in the baseline case without the PPACA, the 55-64 year olds can expect to see a decrease in insurance costs and 27-45 year olds can expect to see an increase in insurance costs.

4.3.3. Medicaid

- 4.3.3.1. Currently enrolled and newly enrolled may find the large increase in enrollment may create long lines of Medicaid beneficiaries waiting to get in to see providers.
- 4.3.3.2. Even after taking into account the federal match for newly eligible that starts at 100% in 2014 and trends down to 90% in 2020, continued growth of the State portion of the Medicaid may run into increased pressure within the overall State budget process which puts pressure on State reimbursement rates which in turn may result in limitations on the size of Medicaid beneficiary panels that may be seen by providers.
- 4.3.3.3. These potential negative feedback loops in Medicaid access may be mitigated during the ramp up and early years of the Medicaid expansion due to increased federal funding of Community Health Centers and the National Health Service Corps (National: ~\$2 billion/year for five years; ~\$87 per new Medicaid enrollee). This feedback loop may be mitigated by relatively generous Medicaid reimbursement rates compared to other states, federal and state funding of Community Health Centers in Alaska, and 100% federal reimbursement of Medicaid services provided to Indian Health Service beneficiaries in Indian Health Service facilities.

4.3.4. Medicare

- 4.3.4.1. PPACA attempts to rejuvenate efforts to address inefficient payment delivery systems by establishing a Center for Medicare and Medicaid Innovation. In addition the PPACA established an Independent Payment Advisory Board (IPAB) to recommend further adjustments in Medicare, with a provision that Congress should either amend the advisory board's proposals or pass an alternative proposal with equivalent budget savings. If Congress fails to act, the Secretary of Health is authorized to implement the proposals.
- 4.3.4.2. PPACA reform law closes the doughnut hole in Medicare's drug benefit by 2020, which may amount to on the order of \$5 billion in new federal coverage for Medicare beneficiaries in Alaska.
- 4.3.4.3. The expansion of health insurance for those under age 65 (Medicaid Expansion + subsidized Exchanges) is financed in part by reductions in the Medicare program relative to what would have been spent otherwise.⁷ Due to rural and near rural exemptions and limitations, these reductions in payment updates may reduce

⁷ See Section 3401 market basket revisions and productivity adjustments, page 3 of 8, Table 3 Estimated Medicare Costs and Savings under the PPACA, CMS OCA, April 22, 2010. Note that the reductions apply to hospitals paid under the inpatient prospective payment system, hospital outpatient services, skilled nursing facilities, part B fee schedules except Physician Services (which has been treated separately and the Sustainable Growth Rate formula has continued to be suspended), inpatient rehab facilities, home health parts A and B, hospice, long-term care hospitals, inpatient psychiatric facilities, and durable medical equipment.

Medicare in Alaska by 3-4% compared to a reduction on the order of 10% in the U.S. in aggregate. The Medicare reductions are expected to more closely track national trends in the Anchorage metropolitan area.⁸

- 4.3.4.4. The combination of the reimbursement reductions associated with the PPACA market basket updates/productivity adjustments and the continuing challenges of Medicare beneficiaries to find primary care providers in Anchorage [UAA ISER 2010, 2011] due to inadequate reimbursement as reported by physicians merits close monitoring by stakeholders to ensure Medicare beneficiaries are able to access care.

4.4. New Taxes and Fees

- 4.4.1. The PPACA raises new taxes and fees including: increase in Medicare hospital insurance for high earned income and investment income, fees on health insurance providers, a 2.3% excise tax on certain medical devices, annual fee on branded drugs, and a 40% excise tax on health coverage in excess of certain thresholds with adjustment for certain high risk professions, indexed to inflation +1%.

- 4.4.2. Due to the high cost of health care and health insurance in Alaska, the 40% excise tax on health benefits above high cost thresholds is expected to be reached by over 50% of the health plans in Alaska compared to roughly 20% in the U.S. by 2019.

- 4.4.3. We estimate that the PPACA taxes and fees, including the 40% excise tax on high cost health benefits, will amount to \$450 million in 2019.

4.5. Combination of Health Insurance Cost Shifting + New Taxes and Fees

- 4.5.1. The combination of cost shifting within the health insurance provisions plus the new taxes and fees may amount to:

- 4.5.1.1. as much as \$8,000-\$10,000 a year in cost shifting and new fees and taxes on to a young healthy self-insured self-employed individual making \$200,000 a year or more and (2019\$) who buys insurance rather than pays the individual penalty of \$5,000 (2.5% of income)
- 4.5.1.2. as much as \$11,200 a year in new cost support to an older worker making less than \$25,345 a year (<150% of FPL in 2019\$)
- 4.5.1.3. as much as \$9,130 a year in new cost support for adults making less than \$23,400 a year (<138% of FPL in 2019) who enroll in Medicaid

5. Impact on Alaska Businesses

5.1. Large Employers (>50 employees)

- 5.1.1. Among large employers who provide creditable health insurance, we expect a small net *decrease* (1-2%) in the cost of employer sponsored health insurance (ESI) as costs previously borne by ESI margins are shifted to the new federally supported health insurance programs

- 5.1.2. Among the few large employers who do not provide health insurance in Alaska (<2% of large firms and <2500 employees statewide), we expect most of them to pay a penalty of

⁸ MAFA Analysis of CMS Medicare Impact Payment files for Alaska.

\$2000 per full time employee above 30 employees or \$3000 for each employee receiving a premium credit in the Exchange rather than figuring out how to split the cost of what will be a single coverage premium approaching \$12,000 (2019 nominal \$) between retail prices and employee contributions through reduced wages or pre-tax health benefit dollars up to \$10,200, and a 40% excise tax on the value above the threshold ($40\% \times \$1800 = \720).

5.2. Small Employers (<50 employees)

5.2.1. Among the ~9,000 small business in Alaska that do not currently offer health insurance to their employees (~45,000), we expect most of them to conclude that they and their employees will find it more financially attractive to continue to offer wages rather than benefits and that around half of those employees will obtain health insurance through the Alaska exchange where federal subsidies that range between \$5000 - \$11000 are slated to be available for incomes between \$23,400 to \$83,670 a year (138%-400% of FPL, 2019) and the other half of those employees may be inclined to pay the penalty of 2.5% of income or \$750 whichever is greater, (\$750 to \$2092).

5.2.2. Among the 58% of employees (~23,000) who are enrolled in health insurance at the 32% of small employers that offer health insurance in Alaska, we expect many of them will confer with their employer to determine how to split the potential savings the firm could realize if it dropped health insurance coverage and employees who were so inclined could then choose between insurance and potential subsidies in the Exchange or pay a penalty.

6. Impact on Overall Alaska Economy

- 6.1. In aggregate, in 2019, we estimate new federal spending associated with the PPACA in Alaska net of taxes and fees and reductions in Medicare and Medicaid to be on the order of \$100 million (<1% increase in total health care spending in Alaska). Within that net total amount of new federal support to Alaska, we expect significant shifts in health coverage, health spending and taxes and fees as described above in household and business impacts.
- 6.2. We also note that the aggregate amount of newly mandated insurance premiums and out of pocket spending not covered by subsidies plus the potential penalties paid by households may be on the order of \$100-\$200 million – representing an internal reallocation away from discretionary spending by households and towards health benefits.
- 6.3. In theory the shift from employer sponsored coverage to individual coverage in the Exchange and Medicaid should reduce “job lock”, i.e., employees who feel locked into a job for its health benefits which should free up employees to seek new employment opportunities more frequently than they may have done in the past.
- 6.4. Given the high cost of insurance and health care in Alaska vs. other states and no indexing in excise tax thresholds for high cost states, the large proportion of health plans subject to the 40% excise tax in Alaska relative to other states may disadvantage Alaska employers. All other things being equal, Alaska employers may have to increase their wage and salary offers in order to attract and retain employees from other states who do not have to pay the 40% excise tax on any or as large a portion of their health benefits.